

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042053

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10537

FILED OCT 31 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

St. Louis

Length of stay in 1b

30 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY
OR
TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

D.O.A. Homer G. Phillips

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)

4224 Penrose St

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

ALLEN

SMITH

4. DATE
OF
DEATH

Month

Day

Year

Oct

20

1963

5. SEX

Male

6. COLOR OR RACE

Col

7. Married ☐ Never Married ☒

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8-7-1909

9. AGE (last birthday)

54

IF UNDER 1 YEAR IF UNDER 24 HR

Months

Days

Hours

Min.

2

13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Janitor

10b. KIND OF BUSINESS OR INDUSTRY

Oceola

Ark

U S A

13a. FATHER'S NAME

Frank Smith

13b. MOTHER'S MAIDEN NAME

Mary Johnson

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Annie Holliday 3960 Palm St

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes

☐ No

☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF
INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

JAS H. RANDLE & SON 3133 Bell Ave

OCT 23 1963

Paul Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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92-3

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Esther H. Harris

Licensed Embalmer No.

4458

P. O. Address

4181 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed; fact should be so stated above.